Patient Information

Patient's Name____

Last First Middle

Address____

Street City State Zip

Home Phone________________ Birthdate__________ Social Security #________________

Email Address________________________General Dentist________________

Responsible Party Information

Name______________________________________ ____________

Last First Middle Marital Status

Residence____

Street City State Zip

Mailing Address____

Street City State Zip

How long at this address__________ Home Phone______________ Work Phone______________

Previous Address (if less than 3 yrs.) ______________________________________

Street City State Zip

Do you own or rent?__________ Email Address______________________________

Social Security #________________ Birthdate__________ Relationship to Patient______________

Employer________________Occupation________________No. Years Employed__________

Other Responsible Party Name______________________________ ____________

Last First Middle Marital Status

Residence____

Street City State Zip

Mailing Address____

Street City State Zip

How long at this address__________ Home Phone______________ Work Phone______________

Previous Address (if less than 3 yrs.) ______________________________________

Street City State Zip

Do you own or rent?__________ Email Address______________________________

Social Security #________________ Birthdate__________ Relationship to Patient______________

Employer________________Occupation________________No. Years Employed__________

Insurance Information

Insured's Name________________Birthdate__________Soc. Sec. #______________

Insurance Company______________________Group No.__________ Local No.__________

Insurance Co. Address____

Do you have dual coverage? Yes ☐ No ☐ If yes: Insured's Employer______________________

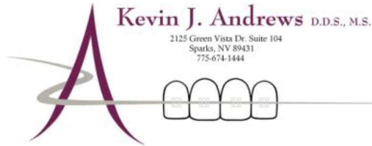
Insured's Name________________Birthdate__________Soc. Sec. #______________

Insurance Company______________________Group No.__________ Local No.__________

Insurance Co. Address____

I understand that when appropriate, a "soft credit check"* may be obtained to assist us in granting you our 0% in-house financing.
*If needed, ask Front Desk personnel for more information.

Signature ______________________________________ Date________________



Date________________________

Patient's Name____ Age_________ Birthdate__________________________________

Grade_______________ School__________________________________ Names of brothers and sisters_____________________________

Plays musical instrument ☐ Yes ☐ No Type of musical instrument__________________________________

Whom may we thank for referring you to our office?____

Previous speech therapy? ☐ Yes ☐ No Hobbies/Interests____

YES **NO** **Medical History**

____ ____ Is patient presently under a physician's care?

For____

____ ____ Is patient taking any pills, medications, or drugs?____

____

____ ____ Has patient ever had an unusual reaction to medication?____

____

____ ____ Is patient allergic to anything?____

____

____ ____ Has patient had any major surgery? For____

____

____ ____ Does patient have a chronic problem with ☐ Kidney, ☐ Heart, ☐ Lung, ☐ Liver.

____ ____ Are there any other medical problems not mentioned above?______________________________________

Describe:____

____ ____ Has patient been diagnosed or treated for any of the following:

☐ Diabetes ☐ Arthritis ☐ Bone ☐ Emotional ☐ Epilepsy ☐ Anemia

☐ Endocrine ☐ Asthma ☐ Fainting ☐ Cerebral palsy ☐ Prolonged bleeding

☐ Heart trouble ☐ Rheumatic fever ☐ Tonsils removed ☐ Adnoids removed

YES **NO** **Dental History**

____ ____ Does patient now suck thumb or fingers?

____ ____ Does patient breathe predominantly through the mouth?

____ ____ Does the patient clench or grind teeth? ☐ at night ☐ during day

____ ____ Does the patient have pain or clicking upon closing the mouth?

____ ____ Has the patient had any severe head or face injuries? When____

____ ____ Have any teeth been injured or chipped due to accidents? When_______________________________________

____ ____ Any noticeable difficulty in chewing or swallowing food?

____ ____ Has patient been informed of any extra or missing teeth?

____ ____ Have any teeth (baby or permanent) been removed by extraction? Why____________________________

____ ____ Has any member of the family had orthodontic treatment? Who_________________________________

____ ____ Have you had any previous orthodontic consultation or treatment?

____ ____ Would patient mind wearing ☐ Bands? ☐ Headgear?

____ ____ Has patient ever been teased about appearance of his/her teeth?

____ ____ Does the patient want his/her teeth straightened?

____ ____ Has a dentist ever placed a retainer or space maintainer? Month of last dental appointment____________________